INSTRUCTION FOR COMPLETING THE INDIVIDUAL VOLUNTEER HEALTH CARE PROVIDER ("VHCPP") APPLCATION/PROTECTION AGREEMENT

The completed application/agreement should sent (email is preferred – you will need to complete and scan the form to email it) to:

Becky Swift
IDPH
Lucas State Office Building, 4th Floor
321 E. 12th Street,
Des Moines, IA 50319
Rebecca.swift@idph.iowa.gov

Questions? Please call Becky Swift at 515-281-4344

SECTION 1 – GENERAL

Name. Enter your first and last names.

Address. Enter your mailing address.

Phone. Enter your preferred phone number, including the area code.

Email. Enter a valid email address. By providing us with your email address, you agree we may communicate with you by electronic mail. The VHCPP prefers to communicate with participants by electronic mail.

License. Enter your current professional license, certification, or registration number and the expiration date. Also check whether this is an initial application (new) or a renewal.

Identify your Profession. Check the box identifying your profession. Check one profession only.

SECTION 2 - PERSONAL HISTORY

Personal History. By signing the document you are providing a sworn statement attesting that your license, registration, or certification to practice is free of restrictions. **IF YOU HAVE HAD disciplinary action or a malpractice suit,** a separate, signed statement giving full details, including date(s), location(s), action(s), organization(s) or party's involved, specific reason(s) and outcome(s) **must** be included for **each incidence** with the application form. **Please use Attachment A of the application for this information.**

SECTION 3 - PROFESSION, PATIENT GROUPS, AND HEALTH CARE SERVICES

Profession. Only complete the section applicable to **Your Profession**.

Note: Below the **Physician Assistant, PA** block, a space is provided for a supervising physician's name and signature. The supervising physician **must** sign this space signifying they have agreed to supervise the PA.

- **Patient groups.** Each profession has up to four patient groups that may be served. For each service checked you must identify which patient groups will be served.
- **Services.** Check the health care services you will be providing at the free clinic.

SECTIONS 4 - 15 - PROTECTION AGREEMENT PLEASE READ THESE SECTIONS CAREFULLY

These sections contain the **Individual Volunteer Health Care Provider** protection agreement. They describe the defense and indemnification that will be provided in the case of legal action taken as a result of your participation in the VHCPP. **Please PRINT your name in Section 4**.

SECTION 16–SIGNATURE OF AGREEMENT

Your Signature is Required. You are not protected for volunteer services provided prior to the signing of the protection agreement by yourself and the Iowa Department of Public Health ("Department"). Once fully executed, this document serves, for five (5) years, as the protection agreement between you and the Department. A fully signed copy will be kept on file and sent to you via email, or by regular mail if requested.